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No. 96-110

IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTIONS PRESENTED

1. Is there a constitutionally protected liberty interest under the Due Process Clause of the Fourteenth Amendment in committing suicide, and if so, does that interest include assistance in so doing?

2. If the answer to the foregoing question is in the affirmative, is a State statute that infringes on the protected liberty interest by prohibiting one person from assisting another to commit suicide nonetheless valid under the Due Process Clause because it furthers legitimate State interests?

3. Is there a rational basis for distinguishing between refusing life-sustaining medical treatment and requesting life-ending medical intervention, so that a State whose law allows the former but not the latter does not violate the Equal Protection Clause of the Fourteenth Amendment?

LIST OF PARTIES

The parties to the proceeding below were:

Petitioners: State of Washington and Christine O. Gregoire, Attorney General of Washington, both of whom were aligned as defendants/appellants below.

Respondents: Harold Glucksberg, M.D., Abigail Halperin, M.D., Thomas A. Preston, M.D., and Peter Shalit, M.D., Ph.D., all of whom were aligned as plaintiffs/respondents below. Three individuals identified only by pseudonyms were plaintiffs in the District Court below, but died during the pendency of the proceedings and are no longer parties to the litigation. A nonprofit corporation, Compassion in Dying, was a plaintiff in the District Court; however, its claims were not adjudicated by the District Court order that prompted this appeal and it is not a party to the appeal.

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I. OPINIONS BELOW

The decision of the *en banc* panel of the United States Court of Appeals for the Ninth Circuit[1] is reported at 79 F.3d 790 (9th Cir. 1996). The Court's Amended Order[2] denying a request that the full court rehear the case *en banc*, with dissenting opinions, is reported at 85 F.3d 1440 (9th Cir. 1996). The decision of the Ninth Circuit three judge panel[3] is reported at 49 F.3d 586 (9th Cir. 1995). The decision of the United States District Court for the Western District of Washington[4] is reported at 850 F. Supp. 1454 (W.D. Wash. 1994).

II. JURISDICTION

The Court of Appeals' opinion was filed and judgment entered on March 6, 1996.[5] The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1). By order of May 14, 1996, the time for filing an application for a writ of certiorari was extended to July 4, 1996.[6] The Petition For a Writ of Certiorari was filed on July 3, 1996, and was granted on October 1, 1996. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

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[1] *Compassion in Dying* II, App. Pet. Cert. at A-1 to A-164. The copy of the opinion reflects changes pursuant to the *en banc* panel's order amending the opinion filed May 28, 1996. A copy of this order is found in App. Pet. Cert. at B-1.

[2] App. Pet. Cert. at C-1 to C-26.

[3] *Compassion in Dying* I, App. Pet. Cert. at D-1 to D-27.

[4] App. Pet. Cert. at E-1 to E-29.

[5] App. Pet. Cert. at A-1.

[6] App. Pet. Cert. at F-1 to F-2.

III. CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

U.S. Constitution, Fourteenth Amendment

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Declaratory Judgment Act, 28 U.S.C. § 2201

(a) In a case of actual controversy within its jurisdiction, except with respect to Federal taxes other than actions brought under section 7428 of the Internal Revenue Code of 1986, a proceeding under section 505 or 1146 of title 11, or in any civil action involving an antidumping or countervailing duty proceeding regarding a class or kind of merchandise of a free trade area country (as defined in section 516A(f)(10) of the Tariff Act of 1930), as determined by the administering authority, any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.

(b) For limitations on actions brought with respect to drug patents see section 505 or 512 of the Federal Food, Drug, and Cosmetic Act.

Washington Revised Code § 9A.36.060

(1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.

(2) Promoting a suicide attempt is a class C felony.

Natural Death Act

Pursuant to Sup. Ct. Rule 24.1(f), the pertinent provisions of Wash. Rev. Code Ch. 70.122, the Natural Death Act, are set forth in the appendix to this brief.

IV. STATEMENT OF THE CASE

A. The Parties And Their Interests

Petitioners are the State of Washington and its Attorney General. They invoke the appellate jurisdiction of this Court to preserve and protect the ability of the people of Washington to determine an important question of public policy—whether Washington law should allow one person to knowingly aid another person to commit suicide.

Respondents are physicians who practice in Washington. J.A. at 5-7. They occasionally treat patients who they believe have no hope of survival. *Id.* Some of those patients have in the past requested that Respondents assist them to commit suicide. *Id.* Respondents' personal ethics would allow them to comply with such requests if received from future patients. *Id.*[7] However, they allege that they are deterred from doing so by Wash. Rev. Code

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[7] Regardless of Respondents' personal sense of ethics, prescribing medication other than for a therapeutic purpose violates state medical licensing standards (*see* Wash. Rev. Code § 18.130.180(6)) and is inconsistent with standards of medical ethics established by the American Medical Association. J.A. at 133-167.

§ 9A.36.060, Washington's statute prohibiting one person from assisting another to commit suicide. *Id.*

Respondents, along with three other individuals and a non-profit corporation, filed suit pursuant to 28 U.S.C. § 2201 and 42 U.S.C. § 1983 seeking a declaratory judgment that Washington's criminal statute prohibiting one person from aiding another person to commit suicide violates the rights of competent, terminally ill individuals under the Fourteenth Amendment of the United States Constitution. Plaintiffs also sought to enjoin enforcement of the statute.[8]

B. The State Statute At Issue

Washington's statute prohibiting one person from assisting another person to commit suicide was initially adopted in 1854 by the first Territorial Legislature. The prohibition has remained in effect throughout the State's history, although the specific language of the statute has varied with different codifications of the State's criminal code.[9]

The 1975 revision of the criminal code retained the prohibition against assisted suicide while at the same time it removed the criminal penalties from the act of attempting

[8] The complaint alleged that the statute violates Respondents' constitutional rights as well. J.A. at 7. These claims were neither argued to the District Court nor resolved by the District Court's order granting partial summary judgment (App. Pet. Cert. at E-28) and accordingly are not before this Court.

[9] Copies of the various legislative enactments, including the statute currently in effect, are found in App. Pet. Cert. at G-1 to G-3.

suicide.[10] The legislative committee whose comprehensive study led to the revision explained:

> "[W]hatever may be said of suicide itself, it seems clear that the introduction into the situation of another person who actively promotes the suicide could well increase the instability or irrationality of the potential suicide, affecting his judgment or emotional outlook. . . . Whatever the thoughts of a potential suicide may be, it is almost inconceivable that the threat of a two year prison sentence if he is unsuccessful in his attempt is going to deter his act. Moreover, it seems clear that such a person is in all probability a troubled, disturbed human being who need[s] psychiatric care or some other counseling service. His condition could only be aggravated by being branded a convicted felon and sent to [prison] for two years. Thus no attempted suicide crime is defined by this [proposed] code."[11]

In 1991, Washington's voters rejected Initiative 119, which, had it passed, would have authorized a form of physician aid in dying.[12] Its enactment also would have presumably created an implied exception to the crime of promoting or aiding a suicide, at least for conduct

[10] *See* 1975 Wash. Laws, 1st Ex. Sess., ch. 249, § 9A.92.010 (214) (repealing former Wash. Rev. Code § 9.80.020, which was originally enacted by 1909 Wash. Laws, ch. 249, § 134).

[11] Legislative Council's Judiciary Committee, *Report on the Revised Washington Criminal Code* 153 (Dec. 3, 1970).

[12] A copy of the initiative is found in App. Pet. Cert. at H-1 to H-10. The initiative was prepared in standard legislative drafting form, reflecting changes in then existing statutory language by underlining language to be added and striking language to be deleted, enclosing the latter in double parentheses.

explicitly authorized by the initiative. The initiative did not expressly amend or repeal the assisted suicide statute at issue here.

Almost all other States also prohibit assisting a suicide, either by statute or by case law.[13] These statutes—generally considered part of the States' homicide laws—have been recognized by this Court as evidencing the States' interest in protecting and preserving human life.[14]

C. The Proceedings Below

1. The District Court Opinion

On cross motions for partial summary judgment[15], the District Court held that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted

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[13] In his dissent from the *en banc* panel decision, Judge Beezer catalogued forty-four States that condemn assisted suicide. *See* App. Pet. Cert. at A-135 to A-136 nn.10-13. The list is extensive, but not exhaustive, because States are continuing to grapple with the issue. Judge Beezer's list does not include, for example, the 1995 Louisiana statute prohibiting "criminal assistance to suicide." *See* La. Rev. Stat. § 14:32.12 (1995 La. Acts, No. 384, § 1). It should also be noted that the Model Penal Code includes a prohibition against aiding suicide. Model Penal Code § 210.5. The Model Penal Code provision and copies of several States' statutes were appended to Petitioners' brief in the District Court and are found in J.A. at 168-86.

[14] *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 280 (1990).

[15] Respondents moved for summary judgment. J.A. at 128-29. In response, Petitioners argued that there were no genuine issues of material fact but that they were entitled to judgment as a matter of law, and that the Court should therefore enter summary judgment for them. *See Cool Fuel v. Conett*, 685 F.2d 309, 311 (9th Cir. 1982). The District Court proceeded as though both parties had in fact moved for summary judgment. App. Pet. Cert. at E-2.

suicide." App. Pet. Cert. at E-16. Finding that Washington's statute prohibiting assisted suicide places an "undue burden" on the exercise of that right, the District Court concluded that the statute violates the Due Process Clause of the Fourteenth Amendment. *Id.* at E-24.

The District Court also held that persons who depend on life support systems to remain alive are situated similarly to those who are terminally ill but able to continue living without life support, and that the refusal or withdrawal of life support by the former is "equivalent" to assisted suicide. *Id.* at E-28. The District Court concluded that by allowing withdrawal or withholding of life support, but prohibiting assisted suicide, Washington law violates the Equal Protection Clause as well. *Id.* Based on these conclusions, the District Court declared the statute unconstitutional. *Id.* at E-28 to E-29.

The District Court granted final judgment declaring the statute invalid pursuant to Fed. R. Civ. P. 54(b) and 28 U.S.C. § 2201, addressing only the claims of the patient plaintiffs and those advanced on their behalf by the physician plaintiffs. *Id.* at I-1 to I-3. The District Court did not reach the claims of the nonprofit corporation, nor the claims of the physicians on their own behalf, as they were not argued to the District Court. *Id.* at E-28. The District Court declined to grant injunctive relief. *Id.* at E-29.

2. The Court Of Appeals Panel Decision

Petitioners appealed to the Court of Appeals pursuant to 28 U.S.C. § 1291. A majority of a three judge panel of the Court of Appeals reversed the District Court, finding that the "decision of the district court lacks foundation in recent precedent [and] in the traditions of our nation." *Compassion in Dying* I, App. Pet. Cert. at D-13. Even assuming the existence of a liberty interest, the panel recognized several State interests furthered by the statute and concluded that "Washington's interests . . .

individually and convergently, outweigh any alleged liberty of suicide." *Id.* at D-14.

Rejecting the District Court's equal protection analysis, the panel also held that "plaintiffs have not sustained [their] burden" (*id.* at D-19) of demonstrating that there is no rational basis for Washington's statutory distinction "between actions taking life and actions by which life is not supported." *Id.* at D-18. Senior Judge Wright dissented. *Id.* at D-20 to D-27.

3. *En Banc* Review

Respondents' suggestion for *en banc* review was granted[16] and a limited *en banc* panel was convened pursuant to 28 U.S.C. § 46(c) and Ninth Circuit Rule 35-3. Following oral argument, a majority of the *en banc* panel "clarified" the scope of the District Court opinion and then affirmed. *Id.* at A-19. Rather than declaring the entire statute invalid, the *en banc* panel held "that the 'or aids' provision of Washington statute RCW 9A.36.060, as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment." *Id.* at A-19 to A-20.

Three judges dissented. Judge Beezer concluded that mentally competent, terminally ill adults have a liberty interest in committing physician-assisted suicide, but that the State's interests "are sufficiently strong to sustain the constitutionality of RCW 9A.36.060 as applied to plaintiffs' asserted liberty interest." *Id.* at A-160. Judges Fernandez and Kleinfeld, in separate opinions, concurred with Judge Beezer, but added that they found no constitutionally

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[16] *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995).

protected interest in committing suicide. *Id.* at A-160 (Fernandez, J., dissenting), A-161 to A-164 (Kleinfeld, J., dissenting).

4. Post-Decision Proceedings

A *sua sponte* suggestion by an active judge of the Ninth Circuit for rehearing before the full Ninth Circuit Court failed to receive a majority of the votes of the non-recused active judges. *Id.* at C-1 to C-2. Pursuant to orders of this Court, the Ninth Circuit's mandate has been stayed pending "the sending down of the judgment of this Court." *Id.* at K-1. The Petition For Writ Of Certiorari was filed on July 3, 1996, and granted on October 1, 1996. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

V. SUMMARY OF ARGUMENT

The clear line between permitting refusal of treatment and prohibiting action intended to cause death is based on well-settled legal doctrines. Whether that line should be disturbed to allow physician-assisted suicide is a complex and controversial issue of public policy which is vigorously debated throughout the land. State legislatures should be allowed to resolve the issue without having their policy choices limited.

The decision below is a radical departure from our nation's legal traditions and this Court's Fourteenth Amendment jurisprudence. Disregarding this Court's restrained analytical approach to substantive due process claims, the Ninth Circuit created a protected interest that is not rooted in our historical concepts of liberty and is different in character and quality from other protected liberty interests recognized by this Court. In addition, the balancing test used by the Ninth Circuit undervalued legitimate State interests that are furthered by the statute at issue.

Moreover, this Court should reject the Ninth Circuit's "as applied" approach to substantive due process claims which focused on hypothetical subsets of the population rather than the needs of society as a whole. If upheld, this approach trumpets a new and intrusive role for the federal judiciary in evaluating the policy judgments of State legislatures and voters.

Washington law does not violate the Equal Protection Clause because those who require mechanical assistance to eat, breathe, and drink are situated differently from those who do not, and the line allowing the former to refuse artificial life support while prohibiting assisted suicide to everyone else is rationally based on these well-settled differences and equally well-settled legal doctrines.

Additionally, there is no principled basis on which the asserted right to assisted suicide can be limited to physician prescription of medication for mentally competent, terminally ill patients to administer to themselves. This Court should decline the invitation to resolve by Constitutional mandate the public policy debate over whether physician-assisted suicide should be allowed.

VI. ARGUMENT

A. The Clear Line Between Permitting Refusal Of Treatment And Prohibiting Action Intended To Cause Death Is Based On Well-Settled Legal Doctrines. Whether That Line Should Be Disturbed To Allow Physician-Assisted Suicide Is A Complex And Controversial Issue Of Public Policy Which Is Vigorously Debated Throughout The Land. State Legislatures Should Be Allowed To Resolve The Issue Without Having Their Policy Choices Limited

This case lies at the intersection of two well-established doctrines in our legal traditions. The first holds

that each of us has the right to withhold consent to medical treatment. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 260-70 (1990). Treatment without informed consent was a battery at common law and remains actionable in most States today, with the inquiry in most cases focusing on whether the patient was adequately informed about the risks and benefits of a particular treatment.[17]

The second doctrine, even more strongly held, is that one who intentionally acts to cause or contribute to another's death is, with rare exceptions, guilty of criminal conduct.

> As this Court has observed:
>
> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280.

The potential for conflict between these two legal traditions arose with the advent of medical machines capable of performing the body's essential functions—breathing, eating, and drinking. While these machines were designed to allow life to be maintained while therapeutic benefits were obtained from other treatments, their use also results in individual situations where life can be mechanically preserved long after death would ordinarily come through the natural progression of the patient's disease or condition. The question then

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[17] The common law rule has been statutorily abrogated in Washington. Treatment without informed consent is actionable only if "a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of [appropriate] material fact[s]." Wash. Rev. Code § 7.70.050(1)(c).

presented is whether the physician's obligation to follow the patient's desires to withhold or withdraw treatment would result in the physician being legally responsible for causing or contributing to the patient's death once those desires are implemented.

That issue—once hotly debated—is now resolved. It is well settled, through a series of lower (mostly State) court decisions and State statutes, that a physician who complies with the patient's choice not to institute treatment, or who implements a patient-directed withdrawal of treatment previously implemented, violates no law.[18] This allows the disease process to follow a natural course to death, while at the same time accommodating the two legal traditions. Patient autonomy is respected while conduct intended to cause death independent of natural forces is prohibited.

Throughout our nation's history, these legal doctrines have been central to the development of substantive law in two areas for which the States have been primarily responsible—regulation of societal conduct through development of the criminal law and regulation of health care practice. Together, they have informed the line that, in the end-of-life context, delineates physician conduct which is permissible from that which is not.

The Ninth Circuit decision below conflated these well-established doctrines with a force that enlarges the first, undercuts the second, and limits a State's ability to accommodate the competing interests served by each. As a result, the clear line of demarcation between what a

[18] In the only case involving this issue to come before this Court, the Court, assuming but not deciding, that there is a constitutionally protected liberty interest in refusing life-saving treatment, upheld a state procedural limitation on the exercise of such refusal. *Cruzan*, 497 U.S. at 284.

physician may do and must not do at the patient's request has been abandoned in favor of one that is difficult to ascertain and inherently unstable.

In this case, the Court is asked to confirm the action of the court below by adopting as a constitutional imperative a public policy that allows physicians to prescribe medications intended not for therapeutic purposes, but to cause their patients to die.

It is difficult to overstate the importance of what the Court is asked to do or the complexity of the considerations which surround it. The issue of physician-assisted suicide has been discussed and debated throughout the nation in a variety of media—from television and radio talk shows to scholarly medical[19] and legal[20] journals to the daily newspapers.[21] Voters in Washington and California have

[19] See, for example, the written testimony submitted to the House of Representatives Judiciary Subcommittee on the Constitution by Kathleen M. Foley, M.D., the Chief of Pain Service at Memorial Sloan-Kettering Cancer Center, on April 29, 1996. Dr. Foley attached to her written testimony a reference list identifying more than 150 articles—most from medical journals—touching on the subject. A copy of Dr. Foley's statement and referenced list may be downloaded via the Subcommittee's home page on the internet (http:\\www.house.gov\judiciary\2167.htm).

[20] See, for example, 18 Seattle U. L. Rev. No. 3 (Spring 1995), 72 U. Det. Mercy L. Rev. No. 4 (Summer 1995), and 35 Duq. L. Rev. (Special Issue) (Fall 1996), each devoted to the issue.

[21] See, for example, Paul Wilkes, *The Case Against Doctor-Assisted Suicide, The Next Pro-Lifers*, N.Y. Times Magazine, July 21, 1996, at 22-27, 42, 45, 50-51; Carol J. Castaneda, *Agonizing over the right to die*, USA Today, June 7, 1996, at 4A; *Doctor-assisted suicide decision*, Seattle Post Intelligencer, March 9, 1996, at A10 (editorial agreeing with decision below); and *Court confuses liberty, death*, The Oregonian, March 8, 1996, at C8 (editorial criticizing decision below).

defeated, albeit by close votes, initiatives that would have authorized forms of physician-assisted suicide in their respective States. App. Pet. Cert. at A-49. Voters in Oregon, by an even closer vote, have adopted a statute allowing what this Court is asked to declare a constitutional right—physician prescription of life-ending medications for terminally ill patients—although implementation of the statute has been enjoined as a result of litigation that may find its way to this Court as early as this term. *See Lee v. State of Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal docketed*, No. 95-35854 (9th Cir. argued July 9, 1996).

In recent years, legislation authorizing physician-assisted suicide has been introduced in the legislatures of at least fifteen States. Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 18 (1996).

Commissions in two of those states—Michigan and New York—have studied the various ethical, medical, legal, social, philosophical, and psychological issues surrounding the physician-assisted suicide debate. Each produced a thoughtful and provocative report, with the differences between their approaches and results illustrative of the complexity of the issues.[22]

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[22] The Michigan Commission on Death and Dying, *Final Report* (1994); The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994). The Michigan Commission produced three separate reports—one recommending a change in Michigan law to allow physician-assisted suicide, one recommending procedures should such a change be made, and one recommending no change. None of these recommendations was endorsed by a majority of the members of the Commission, although the recommendation for a change in the law received more votes than the others. The New York State Task Force Report compiled as thorough an analysis of the various social, medical, psychological, philosophical, and legal issues touching on the assisted suicide debate as can be found anywhere. The Task Force, representing a broad spectrum of divergent view points, unanimously recommended that New York's statutory prohibition against assisting a suicide be retained. New York State Task Force Report at 119-141.

As these reports—indeed the hundreds of articles and books written on the subject—illustrate, the debate over physician-assisted suicide implicates a wide range of interests and points of view, including at least the following:

- Those who, like the patients for whom the Respondents advocate, are mentally competent and terminally ill adults who want to end their lives with physician assistance;
- Those, equally competent and ill, who nonetheless want to remain alive, but fear that allowing assistance to some increases the risk that they themselves may die involuntarily;
- Those who are not mentally competent or terminally ill but who face a risk of being viewed as both and thus placed at increased risk of dying involuntarily;
- Those whose apparent voluntary desire to end their lives may, in reality, be the product of an unrecognized emotional or mental disorder;
- Those who believe that social policy should support life at all costs and in every setting, and those who do not;
- Those who believe that the desires of an individual, even one who may be operating under the effect of a mental disease or disorder, should prevail in all circumstances, and those who do not;

- Those who value self-determination but fear that shifting the line of permissible physician conduct into the realm of assisted suicide will place many vulnerable individuals at risk of an untimely and unwanted death.

This Court should resist the temptation to assert itself as the arbitrator of this complex and challenging issue, and leave the formulation of public policy to the State legislative arena where it has traditionally resided.

B. The Decision Below Is A Radical Departure From Our Nation's Legal Traditions And This Court's Fourteenth Amendment Jurisprudence

The decision below is replete with anecdotal recitations of the toll that terminal illness has inflicted on some individuals as they approach the end of life. *See, e.g.*, App. Pet. Cert. at A-11 to A-13, A-54 n.62, A-57, A-58, A-84 n.98, A-106 to A-108, A-109 n.135. These accounts cannot be read without evoking at least two strong emotional reactions—sympathy for those afflicted, and apprehensiveness that some day a similar fate may befall the reader or a loved one. The proposition advanced by Respondents and apparently subscribed to by the Ninth Circuit—that such suffering would be alleviated by finding a constitutional right to assisted suicide—is unquestionably inviting.

There are, of course, stories that make a different point:

- The story of a New York woman, a multiple sclerosis victim, who committed suicide with the encouragement of her husband. Excerpts from her husband's diary, which came to light after her death, suggested that his encouragement of her suicide was motivated, at least in part, by his own wish to be free of the burden of taking

care of his ailing wife. Rather than face a jury, the husband pled guilty to attempted manslaughter.[23]

- The story of a Seattle man who, though diagnosed with terminal pancreatic cancer, was able with modern pain management techniques to be active until shortly before his death. According to his wife, "[w]e went fly-fishing three weeks before he died . . . . It made all the difference in the world to be able to do things together—continue having fun while living with this knowledge that it's not going to be forever. I look back on those last six months as among the best we had."[24]

- The story of a Virginia woman who was born with cerebral palsy and, among other things, needed several surgeries to connect her malformed esophagus to her stomach. She survived one suicide attempt, and her doctor resisted her thinly-veiled requests that he assist her in another, instead persuading her to undergo yet another surgery. Two weeks after the surgery she was eating on her own, planning a new wardrobe, and contemplating a return to college.[25]

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[23] Herbert Hendin, *Dying of Resentment*, N.Y. Times, March 21, 1996, at A19.

[24] Cecelia Goodnow, *True reliever*, Seattle Post Intelligencer, July 25, 1996, at D1.

[25] Paul Wilkes, *The Case Against Doctor Assisted Suicide, The Next Pro-Lifers*, N.Y. Times Magazine, July 21, 1996, at 22-23.

But this Court's jurisprudence has not been and should not be determined on the basis of anecdotes, no matter what points they make or how compellingly they make them. This Court must focus on the needs of our society as a whole and its role in responding to those needs, and it must do so in a principled manner that builds upon, but does not distort, its prior jurisprudence. The Ninth Circuit decision departed from this Court's jurisprudence in several important respects.

1. The Ninth Circuit's Broad Characterization Of The Issue Ignored This Court's Restrained Analytical Approach To Substantive Due Process Cases

Respondents' claims are cast under the substantive component of the Due Process Clause, which has been recognized as protecting individual liberty against "certain government actions regardless of the fairness of the procedures used to implement them." *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (*citing Daniels v. Williams*, 474 U.S. 327, 331, 106 S. Ct. 662, 88 L. Ed. 2d 662 (1986)). The *Collins* Court observed:

> "As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended. The doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field." *Id.*[26]

[26] *See also Bowers v. Hardwick*, 478 U.S. 186, 194-95 (1986):

> "Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. . . . There should be,therefore, great resistance to expand the substantive reach of [the Due Process Clause] particularly if it requires redefining the category of rights deemed to be fundamental."

This caution is reflected in the Court's analytical approach in due process cases. The analysis "must begin with a careful description of the asserted right.." *Reno v. Flores*, 507 U.S. 292, 302 (1993). The degree of specificity with which the asserted right is described is important and may be determinative of the extent to which the claim of constitutional protection is recognized. *See* Laurence H. Tribe, *Levels of Generality in the Definition of Rights*, 57 U. Chi. L. Rev. 1057 (1990).[27]

In deciding Respondents' claims that their terminally ill patients have a constitutionally protected liberty interest in physician-assisted suicide, the Ninth Circuit *en banc* panel cast its net broadly:[28]

> "[W]e first determine whether there is a liberty interest in choosing the time and manner of one's

[27] For example, in *Bowers*, which involved a challenge to a state statute outlawing sodomy, the majority characterized the issue as whether there exists "a fundamental right [for] homosexuals to engage in acts of consensual sodomy" (*Bowers*, 478 U.S. at 192), while the dissent characterized the issue as whether "individuals [have] the right to decide for themselves whether to engage in particular forms of private, consensual sexual activity" (*id.* at 199 (Blackmun, J., dissenting)).

[28] The Ninth Circuit noted, correctly, that "[u]nder the Court's traditional jurisprudence, those classified as fundamental rights cannot be limited except to further a compelling and narrowly tailored state interest," but that individual liberty interests such as are asserted here are subject to lesser protection. App. Pet. Cert. at A-33. *See also Cruzan*, 497 U.S. at 279 n.7.

death . . . in common parlance . . . Is there a right to die?" App. Pet. Cert. at A-21.

Not only is the breadth of the Ninth Circuit's characterization of the asserted liberty interest inconsistent with this Court's careful analytic approach, it is problematic in other respects as well. If there is indeed a constitutionally protected liberty interest in "determining the time and manner of one's death," not only laws banning assisted suicide are suspect. Also at risk are such statutes as, for example, those prohibiting the sale of transplantable human body parts[29] and denying access to ineffective medications[30], as well as the well-established rule that consent of the victim is not a defense to a murder charge.[31]

Moreover, by phrasing the question—and its answer—broadly, the Ninth Circuit disregarded the *Cruzan* Court's "judicious counsel . . . that in deciding 'a question of such magnitude and importance . . . it is the better part of wisdom not to attempt, by any general statement, to cover every possible phrase of the subject.'" *Cruzan*, 497 U.S. at 277-78 (citation omitted) (second ellipsis in original).

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[29] *See, e.g.*, Wash. Rev. Code § 68.50.610; 42 U.S.C.S. § 274e; *see also* Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—And Why These Reasons Are Not Convincing*, 12 Issues in L. & Med. 113, 114 (1996).

[30] In *United States v. Rutherford*, 442 U.S. 544 (1979), this Court upheld the statutory authority of the Food and Drug Administration to prohibit the sale or distribution of a drug (laetrile) that had not been shown to be effective, rejecting the suggestion that an exception be made for terminally ill cancer patients. On remand, the Tenth Circuit upheld the constitutionality of the prohibition. *Rutherford*, 616 F.2d 455 (10th Cir. 1980), *cert denied* 449 U.S. 937 (1980).

[31] *See, e.g., Martin v. Commonwealth*, 184 Va. 1009, 1018-19, 37 S.E.2d 43 (1946).

The *Cruzan* Court assumed, but did not decide, that "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving treatment and nutrition" (*id.* at 279) and upheld a State procedural limitation on the exercise of the assumed right (*id.* at 284).

This Court should follow its prior teachings, and its *Cruzan* example, and focus its analysis on the narrow issue before it in this case—whether there is a liberty interest protected by the Fourteenth Amendment in committing suicide that includes assistance in doing so.

2. The Asserted Liberty Interest In Suicide Or Assisted Suicide Is Neither Deeply Rooted In Our Nation's History And Traditions Nor Implicit In The Concept Of Ordered Liberty

The Court's principal "guideposts for responsible decision making" (*Collins*, 503 U.S. at 125) in determining the existence of a constitutionally protected liberty interest have been our nation's history and legal traditions. The Court has said that the category of "rights qualifying for heightened judicial protection . . . includes those fundamental liberties that are 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed.'" *Bowers*, 478 U.S. at 191-92 (*quoting Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937)). An alternative statement also recognized by the *Bowers* Court was Justice Powell's characterization of constitutionally protected liberties as those that are "deeply rooted in this nation's history and tradition." *Id.* at 192 (*quoting Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.)).

While conceding the correctness of the *Bowers* Court formulation[32], the Ninth Circuit downplayed the significance of the historical view of our Nation and its legal traditions.

> "Were history our sole guide, the Virginia anti-miscegenation statute that the Court unanimously overturned in *Loving v. Virginia*, 388 U.S. 1 (1967), . . . would still be in force." App. Pet. Cert. at A-36.

Although the result in *Loving* reflected current societal attitudes about relations among people from diverse ethnic and racial backgrounds, the Court based its due process holding squarely on its recognition that "[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness." *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

There is no parallel element of our historical concept of liberty upon which to base the interest in physician-assisted suicide that is asserted in this case.

The limited historical analysis that was conducted by the Ninth Circuit combined a selective reading of the most comprehensive scholarly treatment of legal issues

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[32] The Ninth Circuit's limited *en banc* panel dismissed the holding of *Bowers* on the basis of a subsequent statement by Justice Powell, who voted with the 5-4 majority, that he had "probably made a mistake." App. Pet. Cert. at A-31 n.16. As noted above, page 19 note 27, one difference between the *Bowers* majority and the dissent was their characterization of the issue there involved. However, both the majority and the dissent looked to our nation's history and traditions to determine whether constitutional protection was warranted, and the court below acknowledged that the *Bowers* Court's formulation of the test for the existence of a protected liberty interest "is not controversial." *Id.* at A-31 n.16.

surrounding suicide and assisted suicide[33] with occasional examples of notorious suicides in mythology and literature. *See* App. Pet. Cert. at A-30 to A-47.

This selective and incomplete analysis glossed over the fact that throughout our legal traditions—from the English common law to colonial times to the present—suicide and attempted suicide have been disfavored and have resulted in adverse legal consequences. *See generally* Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1 (1985). For several centuries, the act of attempting suicide was a crime, both in the English common law and in many State statutes. *Id.* at 56-100.

Over time, attitudes toward suicide softened, not because it was considered acceptable, but because of a growing recognition that those who attempted suicide were led to do so because of a mental disease or an emotional disorder, rather than as a noble act of self-determination. Thus, while it is true that "[t]oday, no state has a statute prohibiting suicide or attempted suicide" (App. Pet. Cert. at A-47), virtually every State recognizes a suicide attempt as sufficiently indicative of a mental disorder to justify involuntary commitment for mental health evaluation and treatment.[34]

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[33] Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1 (1985). A thorough explication of the extent to which the Ninth Circuit misread or mischaracterized the historical evidence reviewed in this article may be found in Thomas J. Marzen, et al., *"Suicide: A Constitutional Right"—Reflections Eleven Years Later*, 35 Duq. L. Rev. 261, 262-68 (1996).

[34] See, for example, Wash. Rev. Code §§ 71.05.020(3) and 71.05.240. The New York State Task Force noted that "[s]tudies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." New York State Task Force Report at 11.

Other than noting, correctly, that "[a] majority of states . . . still have laws on the books against assisting suicide" (App. Pet. Cert. at A-47), the Ninth Circuit limited *en banc* panel made no attempt to determine if access to assistance in committing suicide was "implicit in the concept of ordered liberty" or "deeply rooted in this nation's history and tradition."

The reason for this lack of inquiry is, of course, that any such attempt would fail. Though the historical record is incomplete, it appears that most colonial governments viewed assisting a suicide as a common law crime (Marzen, at 70-74, *supra* p. 23), and statutes like the Washington statute at issue here remain on the books in most states. *See supra* p. 6 n.13; *see also People v. Kevorkian*, 447 Mich. 436, 495, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1785 (1995) (holding *inter alia* that assisted suicide remains a common law offense in Michigan today).

The possibility that one who assists a would-be suicide is acting other than altruistically no doubt accounts for the fact that most States continue to view assisting a suicide as a crime.

> "[I]n principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even . . . with the consent, or at the request, of the suicide victim." American Law Institute, *Model Penal Code and Commentaries, Part I*, § 210.5 at 100.

See also supra p. 5 (comments of the drafters of the current version of the Washington statute).

Even if the Ninth Circuit was correct in concluding that suicide has not been universally condemned, the mere absence of universal condemnation does not establish a

right. Neither Respondents nor the Court below have identified any positive source of the asserted right that is "implicit in the concept of liberty."

As the Second Circuit concluded:

> "Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history . . . . Indeed the very opposite is true." *Quill v. Vacco*, 80 F.3d 716, 724 (2nd Cir. 1996) (*cert. granted sub nom. Vacco v. Quill*, Case No. 95-1858, to be argued in tandem with the instant case).

But arguing that the opposite is *not* true, which is all the Ninth Circuit opinion does, does not transform suicide into a right deeply rooted in the nation's history and traditions.

3. The Decision Below Departs From This Court's Substantive Due Process Jurisprudence By Creating A Protected Interest That Is Not Rooted In Our Historical Concepts Of Liberty And Is Different In Character And Quality From Other Protected Liberty Interests Recognized By This Court

This Court's substantive due process jurisprudence has recognized protected liberty interests in marriage,[35] procreation,[36] and the decision to bear a child.[37] In

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[35] *Loving v. Virginia*, 388 U.S. 1 (1961); *Turner v. Safley*, 482 U.S. 78 (1987).

[36] *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Carey v. Population Services International*, 431 U.S. 678 (1977).

[37] *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

according constitutional protection to these activities, the Court considered the nature of the activity, the importance that it plays in the individual's enjoyment of the full range of liberty, and the State interests arguably advanced by the particular governmental restriction involved. The alleged liberty interest in physician-assisted suicide is different in a number of respects than the interests to which constitutional protection has previously been granted.

Each of the Court's earlier cases involved activities that allow the individual a broader participation in life and society, e.g., to enjoy the benefits of marriage to whomever one pleases, regardless of race, or to pursue or avoid the combination of blessings and burdens that parenthood brings.

A decision to terminate one's life, on the other hand, has exactly the opposite effect—once executed, life itself, along with its burdens and benefits, is gone.

The Court has also recognized liberty interests in avoiding unwanted medical treatment[38] and *assumed* that such an interest was implicated even where the treatment consisted of artificial nutrition and hydration necessary to preserve the life of the patient.[39]

Such interests, perhaps more closely analogous to the interest advanced here, are rooted in the individual's freedom from "[t]he State's imposition of medical treatment on an unwilling competent adult [which] necessarily involves some form of restraint and intrusion." *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring).

Assisted suicide invites, rather than avoids, bodily intrusion. The informed consent doctrine on which the

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[38] *Washington v. Harper*, 494 U.S. 210 (1990).

[39] *Cruzan*, 497 U.S. at 267.

Harper/Cruzan line of cases is anchored simply does not provide doctrinal support for the proposition that there is a liberty interest in physician-assisted suicide.

Both the District Court and the Ninth Circuit limited *en banc* panel analogized the interest here to a woman's decision to terminate a pregnancy.

> "In examining whether a liberty exists in determining the time and manner of one's death, we begin with the compelling similarities between right-to-die cases and abortion cases." App. Pet. Cert. at A-25.

While there may be similarities between the two issues, the similarities are superficial at best, and there are significant differences as well. The Ninth Circuit's disregard of those differences is another example of its departure from this Court's cautious analytical approach to substantive due process claims.

First, and foremost, from a constitutional point of view, the abortion decision does not implicate the life of a person.

> "The Court in *Roe* carefully considered, and rejected, the . . . argument 'that the fetus is a 'person' within the language and meaning of the Fourteenth Amendment' . . . [T]he Court concluded that that word 'has application only postnatally.'" *Planned Parenthood v. Casey*, 505 U.S. 833, 913 (Stevens, J., concurring in part and dissenting in part).

Secondly, from a practical point of view, any attempt to regulate the abortion decision perforce impacts women more profoundly than men, seriously implicating equal

protection considerations that are absent in respect to assisted suicide.[40]

Finally, what is at stake in the abortion context is the decision whether to have a child, something over which humans can exercise a great deal of personal autonomy. This case involves death, which ultimately humans have little, if any, ability to control. Death is in fact the antithesis of liberty—neither can coexist with the other. Finding a liberty interest in the former context accords with reality; to do so in the latter does not.

The Ninth Circuit *en banc* panel attempted to anchor its decision on two recent cases from this Court: *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). In reality, it distorted the holdings of both.

(a) *Cruzan*

In *Cruzan*, this Court considered whether Missouri could require clear, cogent, and convincing evidence of a patient's desire before authorizing termination of artificial life support, including nutrition and hydration.

Recognizing that the common law doctrine of informed consent included a co-terminus right to refuse consent, the Court reviewed a series of cases involving intrusive actions, such as immunization and forced medical treatment, and concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Cruzan*, 497 U.S.

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[40] "[S]ome commentators and judges . . . have suggested that the constitutional theory of sex equality . . . better supports the constitutional protection afforded the abortion decision." Marc Spindelman, *Are The Similarities Between a Woman's Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling?* 29 U. Mich. J.L. Reform 775, 824 n.186 (1996).

at 278. However, the Court stopped short of holding that this principle extended to "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water." *Id.* at 279. Rather, the Court stated that "for purposes of this case, [it would] assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* That, of course, did not end the inquiry.

> "Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation." *Id.* at 280.

The State interests recognized in *Cruzan* included "the protection and preservation of human life" as reflected in the universally held view that homicide is a crime and that most states "have laws imposing criminal penalties on one who assists another to commit suicide." *Id.*

The *Cruzan* Court noted that this State interest could justify forced nutrition, at least under some circumstances:

> "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Id.*

The *Cruzan* Court also recognized that the Missouri rule also served "more particular interests"—preventing abuse or undue influence. *Id.* at 281. And it rejected the notion that these State interests varied from one person to another:

> "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life

to be weighed against the constitutionally protected interests of the individual." *Id.* at 282.

Unlike *Cruzan*, this case is not about governmentally forced medical or nutritional procedures. Individuals who require artificial life-support are by definition excluded from the category of individuals on whose behalf Respondents advocate.

To the contrary, Respondents seek to require the government to permit them to take affirmative steps to help their patients die, not as a result of the natural course that is followed when artificial life support is foregone or withdrawn, but as a direct and intended result of an artificial death-inducing intervention.

Such a holding is beyond the scope of *Cruzan* and not supported by the common law doctrine which formed the basis for the *Cruzan* opinion.

Rather than supporting the decision below, the *Cruzan* opinion confirms that the important State interests present in this case outweigh any asserted liberty interest in assisted suicide.

(b) *Casey*

The Ninth Circuit also attempted to anchor its decision on this Court's holding in *Casey*. App. Pet. Cert. at A-56 to A-58. The *en banc* panel attempted to transform a three-sentence passage into a new formulation of the test for the existence of a protected liberty interest. In so doing, it ignored the context in which *Casey* was decided, its focus on the specific issue of "a woman's right to terminate her pregnancy" (*Casey*, 505 U.S. at 844), and the role that *stare decisis* played in the *Casey* decision.

The primary issue in *Casey* was whether the Court should retreat from its "holding that the Constitution protects a woman's right to terminate her pregnancy in its early stages, *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705,

35 L. Ed. 2d 147 (1973)." *Casey*, 505 U.S. at 844. The *Casey* Court declined to do so:

> "After considering the fundamental constitutional questions resolved by *Roe*, principles of institutional integrity, and the rule of *stare decisis*, we are led to conclude this: the essential holding of *Roe v. Wade* should be retained and once again reaffirmed." *Casey*, 505 U.S. 845-46.

Discussing *Roe* and its antecedents, the *Casey* Court noted that the Due Process Clause "affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . [M]atters . . . involving the most intimate and personal choices a person may make in a lifetime." *Id.* at 851.

From the context, it is clear that this language described specific interests accorded constitutional protection in prior cases. There is nothing in content or context to suggest that the *Casey* Court intended this language as a reformulation of the test for determining the existence of a liberty interest.

This is even more clear from Part III of the Court's opinion, explaining the important influence of the doctrine of *stare decisis* in the *Casey* conclusion:

> "Where, in the performance of its judicial duties, the Court decides a case in such a way as to resolve the sort of intensely divisive controversy reflected in *Roe* and those rare comparable cases, its decision has a dimension that the resolution of the normal case does not carry. It is the dimension present whenever the Court's interpretation of the Constitution calls the contending sides of a national controversy to end their national division by accepting a common mandate rooted in the Constitution." *Id.* at 866-67.

In such situations, the *Casey* Court noted:

> "[The Court's] decision[s] require[] an equally rare precedential force . . . [lest] a later decision overruling the first [be seen as] a surrender to political pressure, and an unjustified repudiation of the principle on which the Court staked its authority in the first instance. . . . [T]o overrule under fire in the absence of the most compelling reason to reexamine a watershed decision would subvert the Court's legitimacy beyond any serious question." *Id.* at 867.[41]

In summary, the *Casey* Court reaffirmed the essential holding of *Roe v. Wade* because it was consistent with, albeit an extension of, other substantive due process cases *and* because the Court's institutional integrity required a forceful application of the principles of *stare decisis* to such a "watershed decision" as *Roe*.

That *Casey*'s reaffirmation of *Roe* does not represent an expansion of substantive due process beyond the reproductive rights arena is clear from the *Casey* Court's observation that "*Roe*'s scope is confined by the fact of its concern with postconception potential life, a concern otherwise likely to be implicated only by some forms of contraception protected [by earlier] cases." *Casey*, 505 U.S. at 859.

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[41] These considerations reinforce the need for the Court to be particularly cautious before attempting to resolve the policy debate over whether and under what circumstances physician-assisted suicide should be allowed. This case presents another "watershed" issue involving an "intensely divisive controversy." The Court should refrain from finding a constitutionally mandated answer to this "national controversy," because it cannot do so with sufficient clarity that its answer will withstand inevitable efforts to overturn it and thwart its implementation.

In short, the Ninth Circuit *en banc* panel's reliance on *Casey* was misplaced.

4. The Balancing Test Used By The Ninth Circuit Undervalued Legitimate State Interests That Are Furthered By The Statute At Issue

The Ninth Circuit, having over-stated the nature of the liberty interest involved and under-stated the extent to which recognition of such an interest would depart from our nation's history and traditions, also departed from this Court's substantive due process jurisprudence in the way in which it evaluated legitimate State interests furthered by the Washington statute.

Consider, for example, the *en banc* panel's treatment of this Court's teaching in *Cruzan*, that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Cruzan*, 497 U.S. at 282. While noting this passage, the Ninth Circuit concluded that the "*strength* [of the State's interest] is dependent on relevant circumstances, including the medical condition" of the patient. App. Pet. Cert. at A-65 (emphasis in original). The Ninth Circuit does not explain how a State can, under this construct, assess the strength of its interest without making "judgments about the 'quality' of life that a particular individual may enjoy," precisely what the *Cruzan* Court said a State is not required to do.[42]

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[42] The *Cruzan* Court was aware of Ms. Cruzan's tragic circumstances. *Cruzan*, 497 U.S. 266-67 n.1. If the Ninth Circuit's "sliding scale" approach were correct, it would be difficult to imagine a case where the State's interest would have been weaker. Yet, this Court in *Cruzan* concluded that the general State interests in preserving life and particularized interests in preventing abuse or undue influence

Similarly, the Ninth Circuit considered, and dismissed, other State interests, performing its own evaluation of the "strength" of those interests in the circumstances of the mentally competent, terminally ill patient who wishes to commit suicide. By focusing its analysis on the strength, rather than the nature, of the implicated State interests, the Court below was able to substitute its judgment for that of the Washington Legislature as to which of several competing interests should be given preference.

For example, in recognizing the State's legitimate interest in "preventing deaths that occur as a result of errors in medical or legal judgment," the Court

> "acknowledge[d] that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is sometimes impossible to say for certain whether a borderline individual is or is not mentally competent." App. Pet. Cert. at A-83.[43]

At the same time, the Ninth Circuit ignored the inevitability of "situations in which family members will not act to protect a patient." *Cruzan*, 497 U.S. at 281.

These possibilities raise concerns that any attempt to limit assisted suicide to mentally competent, terminally ill adults will fail, with the result that some individuals will be

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outweighed the individual liberty interest assumed to exist in that case.

[43] This Court has recognized as well "that with diseases such as cancer it is often impossible to identify a patient as terminally ill except in retrospect." *United States v. Rutherford*, 442 U.S. 544, 556 (1979). The Ninth Circuit's failure to articulate a clear definition of when a patient is "terminal" or the standard of "mental competence" to be used in determining eligibility for suicide assistance makes such judgments that much more complicated and error prone.

helped to die even if they do not meet either or both criteria.

Such concerns are, in the Ninth Circuit's view, minimal, because "should an error actually occur it is likely to benefit the individual by permitting [the patient] . . . to end his life peacefully and with dignity." App. Pet. Cert. at A-83. In other words, to the Ninth Circuit limited *en banc* panel, a peaceful death, even erroneously administered, is preferable to an erroneous extension of life.

However, is it not an equally legitimate view that the risk of "wrongful" extension of life is preferable to premature unwanted death? As this Court noted in *Cruzan*,

> "[a]n erroneous decision not to terminate [life support maintains] the status quo; the possibility of subsequent developments . . . at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction." *Cruzan*, 497 U.S. at 283.

The same may be said for assisted suicide.

The Court below also attempted to justify its evaluation of various state interests by comparing Washington's approach to the related—yet different—issue of patient refusal of treatment. Thus, while the State may "assert an unqualified interest in the preservation of human life" (App. Pet. Cert. at A-65 (*citing Cruzan*, 497 U.S. at 282)), Washington's interest in preserving life, according to the Ninth Circuit, is weakened because of the Legislature's adoption of the Natural Death Act, Wash. Rev. Code Ch. 70.122 (App. at 1a-11a), setting forth procedures by which an individual may indicate his or her desire to forego artificial life support.

According to the Court below, this statute reflects "Washington's *recognition* that the state's interest in

preserving life is not always of the same force and that in some cases at least other considerations may outweigh the state's." App. Pet. Cert. at A-68 (emphasis added). However, the statute could just as easily be viewed as a legislative *choice* among competing interests and values in a specific context, a choice that is admittedly different in kind and degree from that reflected in the statute and context at issue here. In any event, the Ninth Circuit did not explain how creation of a statutory right based on common law principles mandated recognition of a constitutionally protected liberty interest inconsistent with the common law.

Certainly, the Washington Legislature did not believe that by enacting the Natural Death Act it was abandoning opposition to assisted suicide:

> "Nothing in [the Natural Death Act] shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." Wash. Rev. Code § 70.122.100.

Similarly, the Court below independently assessed the "strength" of the State's interest in preventing suicides:

> "[W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . In sum, we find the state's interests in preventing suicide do not make its interests substantially stronger here than in cases involving other forms of death-hastening medical intervention. To the extent that a difference exists, we conclude that it is one of degree and not of kind." App. Pet. Cert. at A-82.

While the Ninth Circuit may see no differences between withdrawing life support and assisted suicide, most other courts have.[44]

Consider the following examples:

The Washington State Supreme Court:

- "We emphasize that we are not endorsing suicide or euthanasia." *In re Grant*, 109 Wash. 2d 545, 563, 747 P.2d 445 (1987).

The New Jersey Supreme Court:

- "We would see, however, a real distinction between the self-infliction of deadly harm [suicide] and a self-determination against artificial life support . . . ." *Matter of Quinlan*, 70 N.J. 10, 43, 355 A.2d 647 (1976).

The Arizona Supreme Court:

- "Asserting the right to refuse medical treatment is not tantamount to committing suicide." *Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674 (1987).

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[44] *See, e.g., Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674 (1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court of Los Angeles (Glendale Adventist Med. Ctr.)*, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220 (1984); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 720 (Conn. Super. Ct. 1984); *Staz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978); *State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651, 652 (1989); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626, 638 (1986); *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404, 411 (1987); *Matter of Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 273, 420 N.E.2d 64, 71 n.6 (1981); *Leach v. Akron Gen. Med. Ctr.*, 68 Ohio Misc. 1, 426 N.E.2d 809, 815 (1980); *In re Grant*, 109 Wash. 2d 545, 563, 747 P.2d 445 (1987).

The Maine Supreme Court :

- "[A patient's] decision not to receive [medical procedures], far from constituting suicide, is a choice to allow to take its course the natural dying process set in motion by his physiological inability to chew or swallow." *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (citations omitted).

As this Court has noted:

"It is conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other." *Casey*, 505 U.S. at 851.

It is manifest that the Ninth Circuit's evaluation of the State interests involved differed from that of Washington's Legislature in adopting Wash. Rev. Code § 9A.36.060, and from that of Washington's voters in rejecting Initiative 119. What is not manifest is why one assessment is correct and the other is not.

5. This Court Should Reject The Ninth Circuit's "As Applied" Approach To Substantive Due Process Claims And Uphold Washington's Statute That Furthers Legitimate State Interests

Respondents alleged that the statute is unconstitutional on its face. J.A. at 7. The District Court agreed. App. Pet. Cert. at E-28 to E-29, I-1 to I-3. In their Ninth Circuit Reply Brief, Respondents recast their challenge to the statute:

> "Appellees have challenged RCW 9A.36.060 both on its face and as applied to them individually." Br. Appellees at 29.

The limited *en banc* panel, finding it "extremely unlikely that the district judge intended to strike down the

entire statute" (App. Pet. Cert. at A-18 n.18), transformed the District Court decision into a different kind of ruling:

> "[I]t appears that [the District Court] declared the statute invalid only insofar as it applies to the prescription of medication to terminally ill competent adults . . . or, to use the district court's precise terminology, only insofar as it applies to 'physician-assisted suicide[.]'" App. Pet. Cert. at A-18.

The limited *en banc* panel then held that "the 'or aids' provision of Washington statute RCW 9A.36.060, as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment." App. Pet. Cert. at A-19 to A-20.

By characterizing its ruling as an "as applied" holding, the Ninth Circuit disguised the extent to which it was merely substituting its judgment for that of Washington's Legislature and voters about the appropriate scope of this statute.

The core of the Ninth Circuit limited *en banc* panel's ruling, and of Respondents' argument in this case, is that the statute operates imperfectly, that "as applied" to the hypothetical mentally competent, terminally ill person who decides, free of undue influence or coercion, to commit suicide, the statute serves no legitimate State interest and is therefore arbitrary. However, as this Court has observed in *Cruzan*:

> "[T]he Constitution does not require general rules to work faultlessly; no general rule can." *Cruzan*, 497 U.S. at 284.

And in *Romer v. Evans*, 116 S. Ct. 1620 (1996):

> "Even laws enacted for broad and ambitious purposes often can be explained by reference to legitimate public policies which justify the incidental disadvantages they impose on certain persons." *Romer*, 116 S. Ct. at 1628.

Respondents' argument overlooks the differences between the hypothetical group for whom they advocate and the real world, where the *potential* for abuse and undue influence is present in *every* situation.

As the New York State Task Force concluded:

> "For purposes of public debate, one can posit 'ideal' cases in which all the recommended safeguards would be satisfied: patients would be screened for depression and offered treatment, effective pain medication would be available, and all patients would have a supportive, committed family and doctor. Yet the reality of existing medical practice in doctors' offices and hospitals across the state generally cannot match these expectations, however any guidelines or safeguards might be framed. These realities render legislation to legalize assisted suicide and euthanasia vulnerable to error and abuse for all members of society, not only for those who are disadvantaged. The argument for mercy or compassion then is complex. Constructing an ideal or 'good' case is not sufficient for public policy, if it bears little relation to prevalent medical practice." *See* New York State Task Force Report, at 120.

An "as applied" challenge provides the means for one who is impacted by a law to ask the court to balance the individual liberty interests against the interests of society. It is not an invitation to the court to base its judgment on the law only on how it applies to that individual.

In making public policy, a State legislature—which in Washington and many other States includes the people through the initiative process—must consider a wide variety of interests and strike a balance that, in their collective judgment, best serves the needs of all of the State's citizens.

This Court should reject the Ninth Circuit's use of an "as applied" substantive test to second guess the legislative judgment reflected in the statute at issue here.

C. Washington Law Does Not Violate The Equal Protection Clause

Respondents also claim that Washington's ban on assisted suicide violates the equal protection clause of the Fourteenth Amendment. J.A. at 7.[45] This claim is based on Washington's Natural Death Act[46] which permits an individual to "execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition." Wash. Rev. Code § 70.122.030(1) (App. at 4a). The thrust of their argument is that individuals who seek physician-assisted suicide and those who seek withdrawal of life-sustaining treatment are similarly situated and that

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[45] This issue of whether States whose statutes allow refusal or withdrawal of life support while at the same time prohibiting assisted suicide violates the Equal Protection Clause is more squarely presented in New York's appeal of the Second Circuit's decision in *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted sub nom. Vacco v. Quill*, No. 95-1858, to be argued in tandem with the instant case.

[46] Wash. Rev. Code §§ 70.122.010-.910 (App. at 1a-11a).

there is no rational basis for banning one and permitting the other.[47]

The Equal Protection Clause is "essentially a direction that all persons similarly situated should be treated alike." *Cleburne v. Cleburne Living Center*, 473 U.S. 432, 439 (1985). "The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest." *Id.* at 440.

Respondents have not met the threshold test for equal protection because they have not shown that the two groups are similarly situated. There is a significant difference between terminally ill patients who can breathe, eat, and drink on their own and terminally ill patients who are being kept alive only by artificial means. The patient kept alive by artificial means suffers restraint and bodily intrusion from the unwanted treatment. As Justice O'Connor observed in *Cruzan*:

> "The States' imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion." *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring).

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[47] The District Court ruled that this constituted an equal protection violation. App. Pet. Cert. at E-25 to E-28. This ruling was reversed by the three judge panel of the Ninth Circuit. App. Pet. Cert. at D-18 to D-19. The *en banc* panel of the Ninth Circuit did not reach this question (App. Pet. Cert. at A-115), although its due process analysis was strongly flavored with equal protection principles. *See* pp. 35-38 *supra*; Pet. at 22-28.

A terminally ill patient who is not receiving unwanted treatment is not subject to this restraint and bodily intrusion. The New York State Task Force Report also recognized this distinction:

> "If a patient is denied medically assisted suicide or euthanasia, he or she is likely to die more slowly of natural causes. When a competent patient is denied the option of refusing treatment, he or she will not only have life prolonged, *but must be physically forced to undergo unwanted treatment*. Whether the treatments are highly invasive such as chemotherapy or a respirator, or are generally regarded as less intrusive such as antibiotics, *the patient's body is physically invaded without consent. Under the common law, this is called battery*." New York State Task Force Report at 146 (emphasis added).

In sum, the two groups are not similarly situated because, while both may be said to be terminally ill, only one is suffering from the restraint and intrusion of unwanted medical treatment.

The significant practical distinction between these two groups is plainly rational. It is based on the common law doctrine of informed consent, which includes the right to refuse medical treatment. In *Cruzan*, this Court reviewed a number of State decisions on this point and concluded that:

> "As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." *Cruzan*, 497 U.S. at 277.

This also is the case in Washington. The underpinnings of the Natural Death Act include the recognition that a patient may refuse unwanted medical treatment. *In re Colyer*, 99 Wash. 2d 114, 121, 660 P.2d 738 (1983)

("The common law right to be free from bodily invasion is an alternative basis for the right to refuse life sustaining treatment. Historically, an operation without authorization constituted an assault and battery, as well as malpractice." (citation omitted)).

The distinction between the two groups is also rational because it is based on the strongly held doctrine that one who intentionally acts to cause or contribute to another's death is, with rare exceptions, guilty of criminal conduct. As this Court stated in *Cruzan*:

> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280.

As noted above on pages 35 and 36, Washington did not abandon this doctrine when it adopted the Natural Death Act. Wash. Rev. Code § 70.122.100 provides:

> "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."

In short, the Equal Protection Clause does not provide an alternative basis for upholding the decision below.

D. There Is No Principled Basis On Which The Asserted Right To Assisted Suicide Can Be Limited To Physician Prescription Of Medication For Mentally Competent, Terminally Ill Patients To Administer To Themselves

It may be tempting to believe that the impact of the decision below will be mitigated because, by its terms, it

applies only to "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." App. Pet. Cert. at A-116.[48] If, however, this Court recognizes even a limited constitutional right to physician-assisted suicide, any attempt to confine it to such circumstances is likely to fail.

The Court has previously noted that its "power lies . . . in its legitimacy . . . [which] depends on making legally principled decisions under circumstances in which their principled character is sufficiently plausible to be accepted by the Nation." *Casey*, 505 U.S. at 865-66. In this regard, the Court differs from a legislative body which may, "[c]onsistent with other constitutional norms, . . . draw lines which appear arbitrary without the necessity of offering a justification." *Id.* at 870.

There is no principled basis on which the decision of the Ninth Circuit *en banc* panel can be limited to the prescription of medication for terminally ill patients to administer to themselves. One commentator, who has written widely on the subject, illustrates the problem of trying to limit the newly established right to the terminally ill:

> "If the merciful termination of suffering (or termination of an unendurable existence) is the basis for [the right to assisted suicide], why limit it to those who are terminally ill? . . . [U]nder a variety of circumstances life may be unendurable to a reasonable person, even though he does not face the prospect of immediate and painful death. . . . [I]s it [not] arbitrary to exclude the quadriplegic? The victim of a paralytic stroke? The mangled survivor of a road accident? A person afflicted with severe arthritis? . . . If a competent person comes to the unhappy

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[48] As noted in the Petition at pages 10-11, the substance of the decision below in fact telescopes a much broader impact.

> conclusion that his existence is unbearable and freely, clearly, and repeatedly requests assisted suicide, why should he be rebuffed because he does not 'qualify' under somebody else's standards?" Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, Hastings Ctr. Report 32, 36-37 (May-June 1993) (footnotes omitted) (quotation marks omitted).

Similarly, the newly created "right" to assisted suicide cannot be limited on any principled basis to those who are mentally competent. The Ninth Circuit limited *en banc* panel acknowledged as much:

> "Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." App. Pet. Cert. at A-101 n.120.

The court below also acknowledged that its decision to allow physician-assisted suicide, which it defined as "the prescribing of medication by a physician for the purpose of enabling a patient to end his life" (*Id.* at A-30), was not the final word on whether other forms of life-ending assistance must also be allowed:

> "We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician [i.e., active euthanasia]. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only

> way the patient may be able to receive them." *Id.* at A-100.[49]

Finally, the Ninth Circuit declined to limit its formulation of the newly created right to assistance by physicians, but also included friends, family members, and other health care workers who may facilitate the process within the scope of its ruling. *Id.* at A-116 n.140.

State legislatures, if left unhampered by a constitutional imperative of the sort contained in the decision below, have a broad range of discretion within which to operate on such a complex and controversial subject as physician-assisted suicide. Absent a principled basis upon which to affirm the decision below, this Court should reverse the Ninth Circuit and confirm the States' discretion to balance competing interests in a way that meets the needs of their respective populations.

E. Our Federal System Works Best When Important Questions Of Public Policy Are Resolved Through The State Legislative Process

The Ninth Circuit rejected the argument that the States are capable of forming their own judgments as to whether a policy allowing physician-assisted suicide would meet the needs of their respective populations:

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[49] *See also* App. Pet. Cert. at A-30 n.15 ("The issue of the constitutionality of prohibiting physicians from administering life-ending drugs to terminally ill persons [i.e., active euthanasia] is not before us."). Again, Professor Kamisar's comments are illuminating:

> "If the right to control the time and manner of one's death . . . is well-founded, how can it be denied to someone simply because she is unable to perform the final act herself? Although there is a 'mechanical' distinction between assisted suicide and euthanasia, is it not a distinction without a difference?" Kamisar, at 35, *supra* p. 46.

> "[A]llowing each state to decide whether to *prohibit* [assisted suicide] results [in] a patchwork-quilt pattern of prohibitory legislation." App. Pet. Cert. at A-105 n.124 (emphasis in original).[50]

The same could be said, of course, for a wide variety of contexts in which the States' approaches differ, from real property to contracts to tort liability to criminal law. One could construct an argument that a national rule in any of these areas would have benefits. This was not, however, an argument that the founders of our federal system found to be persuasive.

Nor should this Court. There is great benefit to be gained by allowing each State to grapple on its own with complex issues of public policy such as assisted suicide. Each State can benefit from sister States' experiences, avoiding those approaches that have proven problematic and adapting those that are successful to the needs of their local populations.

As Justice Brandeis pointed out:

> "It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1931) (Brandeis, J., dissenting).

Just as this Court "has the power to prevent an experiment [by striking] down the statute which embodies it" (*id.*), a pre-emptory decision by this Court on the issue

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[50] Of course, there is now no "patchwork" quilt since most States prohibit assisted suicide in all cases, and implementation of the one State statute permitting a limited form of physician-assisted suicide has been enjoined by the federal courts. *See supra* p. 6 n.13; p. 14.

of assisted suicide would freeze the process of experimentation that it presents and forestall the opportunity to learn.

State courts and legislatures are quite capable of resolving these issues *and* protecting individual interests without significant federal judicial assistance. As Justice Holmes observed:

> "[I]t must be remembered that legislatures are ultimate guardians of the liberties and welfare of the people in quite as great a degree as the courts." *Missouri, K.T.R. Co. v. May*, 194 U.S. 267, 270 (1904).

VII. CONCLUSION

For the reasons outlined above, the decision of the limited *en banc* panel of the United States Court of Appeals for the Ninth Circuit should be reversed and this matter remanded to the District Court with directions to enter summary judgment for the Petitioners.

Respectfully submitted this 8th day of November, 1996.

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APPENDIX

APPENDIX A

Chapter 70.122 RCW

NATURAL DEATH ACT

RCW 70.122.010 Legislative findings.

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that, in the interest of protecting individual autonomy, such prolongation of the process of dying for persons with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient. The legislature further believes that physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort.

The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining treatment where the patient

having the capacity to make health care decisions has voluntarily evidenced a desire that such treatment be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health care may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care.

RCW 70.122.020 Definitions.

Unless the context clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Adult person" means a person who has attained the age of majority as defined in RCW 26.28.010 and 26.28.015, and who has the capacity to make health care decisions.

(2) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(3) "Directive" means a written document voluntarily executed by the declarer generally consistent with the guidelines of RCW 70.122.030.

(4) "Health facility" means a hospital as defined in RCW 70.41.020(2) or a nursing home as defined in RCW 18.51.010, a home health agency or hospice agency as defined in RCW 70.126.010, or a boarding home as defined in RCW 18.20.020.

(5) "Life-sustaining treatment" means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

(6) "Permanent unconscious condition" means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(7) "Physician" means a person licensed under chapters 18.71 or 18.57 RCW.

(8) "Qualified patient" means an adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

(9) "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

RCW 70.122.030 Directive to withhold or withdraw life-sustaining treatment.

(1) Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive. The directive, or a copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded by the custodian of the records to the health facility when the withholding or withdrawal of life-support treatment is contemplated. The directive may be in the following form, but in addition may include other specific directions:

Health Care Directive

Directive made this . . . . day of . . . . . (month, year).

I . . . . . ., having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians,

and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.

I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall

have no force or effect during the course of my pregnancy.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed.....

City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness.....

Witness.....

(2) Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be entered in writing and made a permanent part of the patient's medical records.

(3) A directive executed in another political jurisdiction is valid to the extent permitted by Washington state law and federal constitutional law.

RCW 70.122.040 Revocation of directive.

(1) A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer's presence and by declarer's direction.

(b) By a written revocation of the declarer expressing declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the

comatose condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.

RCW 70.122.051 Liability of health care provider or facility.

Any physician, health care provider acting under the direction of a physician, or health facility and its personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment from a qualified patient in accordance with the requirements of this chapter, shall be immune from legal liability, including civil, criminal, or professional conduct sanctions, unless otherwise negligent.

RCW 70.122.060 Procedures by physician—Health care facility or personnel may refuse to participate.

(1) Prior to the withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the directive, the attending physician shall make a reasonable effort to determine that the directive complies with RCW 70.122.030 and, if the patient is capable of making health care decisions, that the directive and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the qualified patient.

(2) The attending physician or health facility shall inform a patient or patient's authorized representative of the existence of any policy or practice that would preclude the honoring of the patient's directive at the time the physician or facility becomes aware of the existence of such a directive. If the patient, after being informed of such policy or directive, chooses to retain the physician or facility, the physician or facility with the patient or the patient's representative shall prepare a written plan to be filed with the patient's directive that sets forth the physician's or facilities' intended actions should the

patient's medical status change so that the directive would become operative. The physician or facility under this subsection has no obligation to honor the patient's directive if they have complied with the requirements of this subsection, including compliance with the written plan required under this subsection.

(3) The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining treatment. No physician, health facility, or health personnel acting in good faith with the directive or in accordance with the written plan in subsection (2) of this section shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.

(4) No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.

RCW 70.122.070 Effects of carrying out directive—Insurance.

(1) The withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the patient's directive in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide or a homicide.

(2) The making of a directive pursuant to RCW 70.122.030 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life

insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining treatment from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(3) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

RCW 70.122.080 Effects of carrying out directive on cause of death.

The act of withholding or withdrawing life-sustaining treatment, when done pursuant to a directive described in RCW 70.122.030 and which results in the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of anyone that placed the declarer in a terminal condition or a permanent unconscious condition and the death of the declarer.

RCW 70.122.090 Criminal conduct—Penalties.

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarer's consent shall be guilty of a gross misdemeanor. Any person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in RCW 70.122.040 with the intent to cause a withholding or withdrawal of life-sustaining treatment contrary to the wishes of the declarer, and thereby, because of any such act, directly causes life-sustaining treatment to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for murder in the first degree as defined in RCW 9A.32.030.

RCW 70.122.100 Mercy killing or physician-assisted suicide not authorized.

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

RCW 70.122.110 Discharge so that patient may die at home.

If a qualified patient capable of making health care decisions indicates that he or she wishes to die at home, the patient shall be discharged as soon as reasonably possible. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient. If the provider or facility complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge.

RCW 70.122.120 Directive's validity assumed.

Any person or health facility may assume that a directive complies with this chapter and is valid.

RCW 70.122.900 Short title.

This act shall be known and may be cited as the "Natural Death Act".

RCW 70.122.910 Construction.

This chapter shall not be construed as providing the exclusive means by which individuals may make decisions regarding their health treatment, including but not limited to, the withholding or withdrawal of life-sustaining treatment, nor limiting the means provided by case law more expansive than chapter 98, Laws of 1992.